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Good morning, Mr. Chairman, Ranking Member Deal and Members of the Committee. Thank you for the opportunity to talk about how Congress might change the payment structure it provides for medical care and how realigning incentives might lead to better quality care and a more structured physician workforce designed to meet the needs of the Medicare population.

My name is Dr. Bruce Sigsbee, and I am a neurologist representing the American Academy of Neurology, a medical specialty association with more than 21,000 members. I am also in private practice at Pen Bay Physicians and Associates in Rockport, Maine, where I serve as medical director. I am responsible for quality and until recently physician contracting and budgets.

Neurology is responsible for caring for a large spectrum of significant diseases in the Medicare population including Alzheimer's, Parkinson's, ALS, and stroke among many others. Not only are these disorders large contributors to the societal burden of long-term care and consumption of resources, in the future with the aging of the baby boomers, the burden will be substantially increased and will require skilled management to improve quality of life and constrain inappropriate resource utilization.

Where I practice in Maine, we have a mix of patients and payers, of insurance and Medicare, of specialists and primary care providers. We use an electronic medical health record for all of our hospitalized patients and are in the process of implementing an EMR for office patients. We believe that we practice high quality, evidence-based medicine in a group setting. However, in reality, no one who interfaces with the healthcare delivery system is happy, including the patients, physicians and those that pay for the care.

The misaligned incentives of the current Medicare fee schedule are now well appreciated and its consequences include expansion and overuse of some healthcare services and underuse of others. The focus should always be on what the best available evidence indicates the individual patient needs. The Dartmouth Atlas insights indicate the potential savings from a correctly crafted compensation system without sacrificing quality or even improving quality.

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An example of the misaligned incentives is the current crisis in primary care. Both family practice and internal medicine US residency slots are only 50% filled by graduating US medical school seniors at a time that the number of graduating seniors is expanding. For those that select internal medicine, less than 5% elect to go into primary care as compared to 60% in 1996. These numbers are similar for cognitive service dependent specialties such as neurology that are in the same crisis. As pointed out in a recent Journal of the American Medical Association (JAMA) article 52% of neurology residency slots are filled by US graduating seniors. There is a current shortage of neurologists across the country. In my own practice, we have been recruiting for over four years without success. As a consequence, we may be unable to continue the Joint Commission Stroke Center, currently only one of two in the state. This imbalance leads to a problem with patient access to care for primary and cognitive care.

For Medicare, balance of specialties is crucial to providing the vast array of medical services needed by patients. An ideal system would include a physician and a team set up to coordinate the care of patients by providing the care necessary and eliminating unneeded, duplicative, or defensive care that costs the Medicare program dearly.

We think that Congress has recognized this need and is set to take steps to improve the incentives for residents entering primary care. The Academy of Neurology supports these efforts and stands ready to help when Medicare patients need more than primary care for diseases such as Alzheimer's disease for which primary care practitioners are not trained. Unlike other specialties, those in primary care residency have little or no exposure to neurology and some other specialties. Despite the array of diagnostic testing available, patients with neurologic problems require a sophisticated history, examination and integration of the diagnostic tests to arrive the correct diagnosis and select appropriate management. The primary care community depends on neurology to provide consultation or to provide ongoing management of these patients. Often, neurologists become the "principal care" providers for these Medicare beneficiaries.

We think that one of the main goals of health reform should be to return to a greater emphasis on face to face time between physician and patient, with more time for preventive care, counseling, and support for adjustment to illness, encouragement of lifestyle changes and less reflexive prescriptions, diagnostic tests and referrals. If successful, the result would be higher quality patient care, better outcomes, and lower cost.

At this time, however, procedures such as colonoscopy, stress test, minor out-patient surgical procedures or cystoscopy among many others, receive higher compensation on a per unit time basis compared to evaluation and management services, or face to face patient care. As a result, those specialties that provide the bulk of their services as evaluation and management services are less well compensated than those that are procedure based. The Medicare fee schedule is a national fee schedule since most payors adopt the fee schedule and payment rules of Medicare. This fee schedule must be viewed as an incentive program. The current problems of excessive procedures and services with escalating costs are the results of those incentives built-in to the current system. In other words, Congress is getting what it pays for, which is more and more procedures. This is not to suggest that procedure based services be

cut, only that incentives be provided to encourage new physicians to go into primary care or any specialty he or she wishes.

Workforce: This fact has a profound impact on the physician workforce. Medical school seniors with substantial educational debt burden often select specialties with higher anticipated income so they can retire their debt. As noted above, a recent JAMA article details the fill rate of residency slots by graduating U. S. medical school seniors. Neurology's fill rate is between that of family practice and internal medicine. As a result, the number of available physicians in neurology and other cognitive specialties is declining at a time when it is anticipated that there will be a substantial increase in demand for medical services for the Medicare aged population as the baby boomers enter their 70s and 80s. For neurology, it is anticipated that there will be a substantial demand for services for people with stroke, epilepsy and neurodegenerative disorders of the nervous system such as Alzheimer's and Parkinson's disease and other age-related disorders affecting the nervous system. On consultation with a number of patient advocacy groups, they universally note that there is already an access problem and a lack of sufficient neurologists to manage the disease complexity.

Research: The same disparity in anticipated income impacts the specialty choice of bright young physicians with an interest in research. Department chairs note that often there is less support for researchers, research space and support staff because the specialty brings little revenue to the institution. Intensive research is needed for these neurologic based diseases to provide improved quality of life and reduce the cost burden to society. As only one example, nearly 50% of individuals who are 85 and older have Alzheimer's disease. This burden on entitlement programs and society as a whole has the potential to overwhelm available resources unless effective interventions are identified.

Quality: A culture of quality and safety should be embraced by the medical community. Best practices leading to the best possible outcomes for patients should be a primary concern for everyone. However, there is currently no incentive to focus on quality within the fee schedule; rather, there are disincentives to doing so.

No physician thinks that he or she practices at a less than excellent level, yet there are many studies that document mediocre quality of medical care across the country, such as the RAND Corporation study which shows that patients get recommended care about 50% of the time. Why this disparity? First of all, medical information doubles every eight years. It is difficult to keep up. The American Academy of Neurology has addressed this information gap by developing over 110 clinical practice guidelines. The AAN takes this task seriously. Our guidelines are based on the evidence—not opinion—and are meant to be used together with our members' experience and knowledge of their patients in order to improve care. Rigorous policies manage conflicts of interest and no pharmaceutical funds are used. Independent reviewers (including a study done at Johns Hopkins University) praise AAN guidelines, which meet all of AHRQ's criteria for high-quality guidelines. Neurologists share this commitment to quality; 81% use the guidelines in their daily practices.

The second major reason for gaps in care is that quality improvement requires measuring care and making needed improvements. Both of these steps require resources not valued in the current system.

Quality systems in ambulatory medicine are in their infancy and those systems that exist require time and expensive support staff and systems such as electronic healthcare records. As a personal example, my group of fellow neurologists successfully met Joint Commission requirements for a Stroke Center, one of only two in Maine. Prior to the monitoring of quality measures we were not performing at the level we thought or expected. With monitoring and feedback, our performance consistently exceeds stroke center performance.

Although we have been successful, there is no incentive provided by Medicare to make this commitment. In fact there are substantial disincentives. As one family medicine physician queried recently to me, "How much are you willing to have my productivity decline to focus on these quality initiatives, 10%, 20%, 30%?" The barriers include the effort of establishing complex systems that are accurate and monitor the right elements, the cost of those systems and the lost patient care revenue. Physicians are focusing on the complexities of patient care and are very sensitive to anything that threatens their ability to focus on patients.

As a medical director responsible for quality in a multispecialty group I find engaging physicians in quality initiative extremely difficult. It is not valued as a productive use of time. While all physicians agree that quality care is important, only a few are committed to the effort required. If one views the financial recognition of an endeavor as a measure of the value placed in that endeavor, the current Medicare fee schedule does not value quality.

Therefore, it is essential that quality programs are low burden and provide actionable information. In this regard, the PQRI as an incentive program has failed as currently implemented. Feedback is delayed to well after the completion of the year and individuals in my multispecialty group still do not know how they performed. Where quality measures have worked, the patient care monitored contributes to outcomes and quality of life, a survey is done frequently and physicians are given constant feedback and suggestions and support systems to improve performance. The stroke center is an excellent example. The key elements include a physician champion, order sets that included all the needed elements and a coordinator that constantly monitors results.

There is a realistic perception that quality initiatives are often a thinly veiled effort to control costs. Most pay-for-performance programs are based on claims data. That data is limited for quality purposes but is excellent for assessing costs and resource utilization. Those programs are often a proxy for cost containment, not quality. I believe that neurologists would participate if programs are low burden, provide actionable information, and primarily seek to improve quality. The AAN is participating in national efforts that have these goals, such as NQF, AQA, and the AMA's Physician Consortium for Performance Improvement (PCPI). AAN has developed measurement sets on stroke and epilepsy and is working on more. We are well poised to contribute high quality measures to programs that truly seek to improve care.

Origins of Imbalance in Current Medicare Fee Schedule

It is worthwhile reviewing the origins of the current fee schedule. A key consideration is whether or not the current system of maintenance can be salvaged and can serve as a mechanism to correct the distortions within the schedule. RBRVS (Resource Based Relative Value Scale) arose out of recognized substantial variations in payments for the same service based on geography and out of a recognition that primary care was not adequately recognized in the then existing usual, customary and reasonable payment system. In other words, basing the payments on inputs, work, expense and malpractice with the same national schedule intended to create a fair and equitable method of compensating physicians.

The original studies that set the work component of the RBRVS were based on magnitude estimation. Magnitude estimation established the rank order and magnitude of work for sample procedures within specialties. Within specialties the results were consistent, achieving a high degree of correlation. However, the linkage across specialties was problematic. Focus groups established links across specialties but did not have the same rigor.

Several problems arose almost immediately. First, physicians protected what they viewed as important revenue sources to protect the viability of their practice. Second, the linkage across specialties became problematic, which continues today.

The Centers for Medicare and Medicaid Services (CMS) is charged with maintaining the RBRVS. However, CMS depends heavily on the AMA Relative Value Update Committee (RUC) to offer provider input into new and revised codes and to correct rank order anomalies. From the inception, there have been problems with this process. At the very core is that once the RBRVS became the basis for payment, the economic consequences of changes in work RVU values was immediately evident. Specialty societies represented their constituents and attempted to protect or augment their income. Since the RUC is dominated by procedural specialties, it is those specialties that have benefited by new procedures and analysis of rank order relationships. The survey process was never statistically valid and was contaminated by the economic implications of determinations. Further, approximately one half of the work RVUs for major surgical procedures represent evaluation and management services before and for 90 days after the procedure. There are no documentation requirements for these services and the level is based on assertion. Given the economic implications, the reported frequency and level of these services is difficult to validate. More recently, extant databases, never intended for compensation determination, are now accepted for determination of work RVU values and to establish rank order. These databases are relevant only to procedural specialties and do not exist for evaluation and management services. While not malicious and in large part based on the understandable responsibility of representatives to protect their specialty, the RUC process is notably flawed and has contributed to the current imbalances. The original researchers raised the concern that the RBRVS would progressively disadvantage evaluation and management specialties such as primary care and cognitive specialties shortly after implementation.

However, the major contribution to the misaligned incentives probably arises not so much from inter-specialty distortions, it probably actually arises from the use of RVU values. There is ample evidence

that high volume and relatively low RVU value out-patient diagnostic tests are the major source of the imbalances, even within specialties. For example, in urology, a physician is rewarded far more for performing several cystoscopies than for performing a complex all-day radical prostatectomy with a 90-day global follow-up period which is included in the fee. For large RVU numbers, a material difference is immediately evident. For small numbers substantial differences are not as evident. For example, the difference between 1.50 and 2.25 work RVUs does not seem all the great, but a 33% greater payment over many procedures can make a substantial difference. The base process for maintaining the work RVU system does not easily address services with relatively small RVU numbers. Combined with a survey process that is not statically valid and the use of databases available to only certain specialties, this results in a maintenance process that is flawed if not broken.

In sum, medicine and procedures change. The current system is materially flawed and cannot be relied upon to correct the imbalances and is not a reliable mechanism for maintaining the Medicare fee schedule into the future.

A Fee Schedule Based on Patient Care

The fee schedule should be based on the physician effort to provide direct patient care rather than providing volume of care.

Physicians should be recognized for the services they actually perform and should be held to the same standards as others for requirements such as documentation. Currently, there are material flaws in the comparisons across specialties, flaws in the rank order of procedures within specialties, use of methodologies that do not reach statistical validity and use of actual RVU data which contaminates any result with economic considerations resulting in a fundamentally flawed process. Changing the composition of the RUC would not correct the current imbalances. Some inequities would be corrected but many would not. To correct the imbalances that infuse the whole schedule would require a total revision. Such an effort should be expended on a payment methodology that focuses physician efforts on direct patient care rather than volume. The ultimate goal should be to find a method that, while not perfect, serves patient care, provides proper incentives and recognizes the great responsibility and effort represented in the role of being a physician.

Characteristics of a Future Payment System

Many possible payment methods are raised by policy makers, including the medical home, bundled payments and accountable healthcare organizations. Any one of these could probably work. Currently, there is not adequate information to identify the preferred method.

Perhaps we all need to take a step back. The goal is to provide high quality, patient focused care. Within that goal should be fair recognition for physician work and incentives that encourage excellence and improve outcomes and quality of life.

There are different ways to compensate physicians. Physician compensation may be salaried, purely based on productivity or a blended method. A major decline in productivity is observed when physicians are salaried. Physicians that are on a purely productivity method of compensation focus on keeping productivity and emphasize their individual efforts but are less likely to focus on systems of care, peer review and quality. Most groups are successfully using a blended system that includes a base salary which not only requires a certain level of productivity but requires participation in the medical community. Some refer to this component as "medical citizenship." Up to 35% of the compensation is variable or at risk. The metrics for this at risk component typically are heavily weighted towards productivity but also includes measures of quality performance, patient satisfaction and medical citizenship. Lessons for a compensation system can be taken from both the practical experience of healthcare systems as they compensate physicians and the body of literature on this topic.

We suggested that this same blended approach to physician compensation be included in any reform and be based on the experience that currently exists to help design a system without decades of demonstration projects and pilots that delay correction of the currently flawed system. In order for this type of system to work, it would have to provide incentives for coordinating the care of Medicare beneficiaries, especially those with chronic disease that incur a large percentage of Medicare resources. The result will be that physicians will be encouraged to provide high quality care that reduces the use of unnecessary care and improves the quality of life of the patient.

As medicine becomes more complex, good outcomes and efficient use of resources requires not only physician engagement, it requires the establishment of effective systems of care. Any method of physician compensation must include recognition of both the individual physician's efforts but also the role of that physician in a larger medical community necessary to deliver that care. The payment system and the incentives inherent in that system will be critical to the evolution of healthcare delivery in this country.